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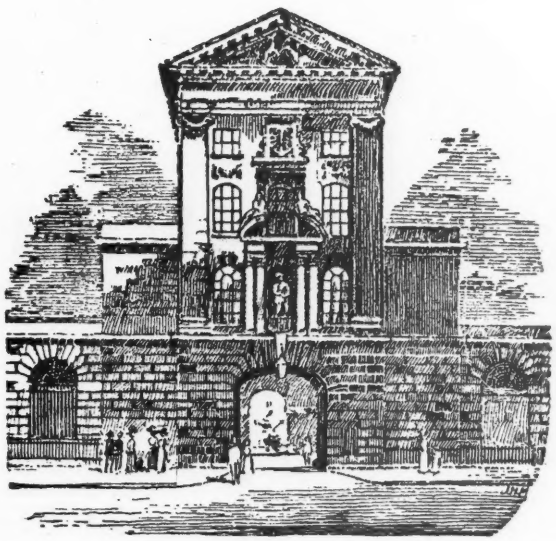
ST. BARTHOLOMEW'S HOSPITAL JOURNAL



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"Æquam memento rebus in arduis
Servare mentem."
— *Horace*. Book ii, Ode iii.

VOL. XXXIV.—No. 10.] JULY 1ST, 1927. PRICE NINEPENCE.

CALENDAR.

Fri.,	July	1.—Sir Percival Hartley and Mr. McAdam Eccles on duty.
Sat.,	,,	2.—Cricket Match *v.* Hornsey. Away.
Tues.,	,,	5.—Sir Thomas Horder and Mr. L. B. Rawling on duty.
Thurs.,	,,	7.—Cricket Match *v.* C.I.D., "N" Division. Home.
Fri.,	,,	8.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Tues.,	,,	12.—Prof. Fraser and Prof. Gask on duty.
Wed.,	,,	13.—Cricket Match *v.* Moorcroft House. Away.
Fri.,	,,	15.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Sat.,	,,	16.—Cricket Match *v.* Hampstead. Home.
Tues.,	,,	19.—Sir Percival Hartley and Mr. McAdam Eccles on duty.
Thurs.,	,,	21.—**Last day for receiving matter for the August issue of the Journal.**
Fri.,	,,	22.—Sir Thomas Horder and Mr. L. B. Rawling on duty.
Sat.,	,,	23.—Cricket Match *v.* Rams. Home.
Tues.,	,,	26.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Fri.,	,,	29.—Prof. Fraser and Prof. Gask on duty.

EDITORIAL.

THE month of July should bring with it many consolations for your Ordinary Man. June has been genuinely bad for him. Dickens has been openly mocked in Hammersmith. In June the Eclipse with its attendant prophesies of dissolution has made him repent; and this can be remedied in July. In June Lady Oxford published another book in which she twisted his Bible into politics; this can never be remedied by the end of July, but the buzz of it may die down. There will then be no more anxiety for him about the relation of the weather to Wimbledon and the more important Hospital fixtures. Grand opera will have given place to Russian ballet; and the Spook Sonata will have claimed its last victim, demented by ceaseless inquiries into the state of its author's strange mind, or will in the living have created the state described by W. B. Yeats in his latest poem, when—

> "Imagination ear and eye
> Can be content with argument and deal
> In abstract things; or be derided by
> A sort of battered kettle at the heel."

For the intellectual masters of your Ordinary Man have been divided; they are earnestly concerned about symbols being "harmonic undertones," and are debating over "Neo-classicism as a repressive instrument of literary criticism." They have levelled the first attack against his idol Community Singing, saying that "it obviously cannot be explained by a new passion for music; it seems to have more in common with what Matthew Arnold illustrated by 'bawling, hustling and smashing' and breaking the Hyde Park railings."

These and other difficult things have made him in that same hated Strindberg's understanding words: "To feel my vision weakened by an eye, my hearing blunted by an ear, and my thought, my bright and buoyant thought bound in labyrinthine coils of fat."

In fact our hero needs a holiday. July should help him to it.

* * *

To remind our readers that the Sixth Annual Contest for the *Financial Times* Challenge Trophy between Banks, Insurance Offices, Stock Exchange and United Hospitals will take place at the Crystal Palace on Saturday, July 16th.

The Hospitals have won the Shield for the last two years, and if they turn out their best team, should go close to retaining it for another year.

Tickets 1*s.* 6*d.* each, including admission to the Palace. Return tickets at special fare 1*s.* 6*d.* first class, 1*s.* third (not including admission to the Palace), will be issued from the London stations of the Southern Railway.

The proceeds are divided between the Hospitals comprising the U.H.A.C. Since the inception over £900

has been raised. Last year a sum of £250 was divided. Let's hope a greater sum will be found this year, and so make a record in the year of office as President of our Senior Physician, Dr. H. Morley Fletcher.

* * *

The occasion of Sir Berkeley Moynihan's recent address on "Medicine and Art" was extremely successful from start to finish. The lecturer is so conversant with his twin subjects that he can give a number of addresses having this title which do not apparently overlap. On June 29th he dealt mainly with Hystero-epilepsy and Achondroplasia as they are depicted in works of art.

* * *

OLD STUDENTS' OCTOBER DINNER, 1927.

The above dinner will be held in the Great Hall on Monday, October 3rd, at 7 for 7.30, with Dr. Morley Fletcher in the Chair.

As many old students have expressed a desire that more time should be available at the dinner for conversation, it has been decided on this occasion that there shall be no toast list. The Chairman will make a statement after dinner dealing with the progress of the College during the past year, but there will be no formal speeches.

Coffee and other refreshments will be served in the Library after dinner.

Notices will be sent out to all those whose addresses are available and guests may be invited.

The price of the dinner will be 26/- and tickets may be paid for at the time of the dinner.

The Honorary Secretaries hope that these modifications will attract a large attendance.

Many of the old students have from time to time expressed the view that the price of the dinner is too high. The Honorary Secretaries have made every effort to provide a less expensive dinner, but in view of the fact that the caterers have to bring all their crockery and cooking equipment with them in order to serve dinner in the Great Hall, charges are of necessity higher than for a dinner served in a restaurant.

All communications with reference to the dinner should be sent either to Sir Charles Gordon-Watson, 82, Harley Street, or to Mr. Reginald M. Vick, 113, Harley Street.

* * *

We take this opportunity of reminding intending contributors that no contribution can be accepted without the name and address of the author. The correspondence columns have lately been full of vituperation which might have been launched at us had we not redirected it.

THE ROMANCE OF EMBRYO-PATHOLOGY.*

BEFORE the beginning of the present century the anatomy of the human subject pre-eminently held sway in the curriculum of the medical student, and particularly of the surgeon. To have a thorough and practical knowledge of the intracacies of the human frame was essential for the operator, and really indispensable for the general practitioner. Many a surgeon, and not a few country practitioners, made their fame upon the foundation of anatomy.

Comparative anatomy was a fascinating subject, elucidating many of the tangles of evolution.

Then pathology began to loom largely on the horizon, and has now come into its own. No physician, no surgeon, no specialist, no general practitioner is worthy of his salt unless he or she can think or act in the terms of pathology.

Crude morbid anatomy has its place, and a very definite place at that. What is seen in "end-results" in the post-mortem room is of high significance in the estimation of the origins of disease, but it is in the laboratories of the wards, and in those of chemical pathology, of bacteriology and of clinical pathology that much more of the ætiology and progress of disease is investigated and tabulated.

After all is said and done, it is desirable to discover why our mortal bodies cease to live, even although it might not be a good thing to prevent their dissolution. We die because others have to live. We die because we become the habitat of parasites. We die because we fall victims to "accident"—preventable, and therefore sheer carelessness; unpreventable, and therefore "the act of God." We die because we wear out in the endeavour to live, but very few depart in this manner.

Given a healthy adult body, fitted with all the niceties of the human machinery, it is foolish to allow the works to grind instead of running smoothly. Hence preventive medicine has come to stay, and marks the altruism of the profession.

But it is not of these matters I desire to speak, however fascinating they are to all of us. It is quite another, and, may I say, even more fascinating an item in the wheels of progress of pathology and treatment to which I wish to direct your attention. I allude to embryo-pathology, and particularly as applied to surgery. Embryo-pathology concerns literally all parts of the body from head to foot. Normal embryology is mystical; abnormal embryology—that is, pathological

* The Bolingbroke Lecture delivered before the South-West London Medical Society on June 8th, 1927.

embryology—is even more mysterious. We are still quite in the dark as to the actual forces which cause the various cells of the embryo to develop along prescribed lines. Vitamines, hormones, the influence of nerves, the distribution of vascular supply, or even the position of the embryo *in utero* may all play a part in moulding the future individual.

What is more difficult of explanation, for instance, in embryology than the closure of the lateral halves of the body in the middle line?

Think of it: that closure along the mid-ventral line of the abdomen, a perfect closure without the semblance of a scar, save at the umbilicus. Such is the perfection of Nature's surgery!

Where in the ovum lies the force which induces this union along the whole length, but without any interference with the passage of blood from the placenta to the fœtus? It is in the consideration of this and similar facts that the most learned appear as children before stupendous possibilities. But if this closure is mystical, what of the non-closure in this and other lines? While we know little as to the reason of the closure, we know less as to the cause of the non-closure.

A brief survey of some of these lapses from perfection is, therefore, not without interest and profit.

HARE-LIP.

Imagine the agony of a mother on beholding her firstborn with a cleft in its upper lip like that which is natural in the hare. If the cleft is bilateral and complete, with protruding intermaxillary bones, the appearance of the infant is truly repulsive. Embryo-pathology explains "how" the condition occurs, but not the "why" thereof.

It tells us that there has been a failure in the normal coalescence of the labium and the prolabium to form the anterior naris, but it is silent as to why this abnormality has occurred in this particular infant.

Some suggest "reversion to type," but why should this singular unborn fœtus think thus of its ancestors? Others hint that the failure is an intra-uterine effect of inherited syphilis. Possibly not, but if it were, then why should the spirochæte hit on such a remarkable method of showing its power? Is it merely "an arrest of development"? Yes, perhaps, but why at this particular spot? May it be due to want of proper innervation in this local area? Very likely, but what led to this failure of the usual nervous influence? Is it owing to the failure in the production of the secretion of a certain hormone? Possibly, but what brought about this lack of secretion, and why did the absence affect this particular spot?

Maternal impression has been alleged as a cause, but the "impression" on the mother is usually found to have been far too late in the intra-uterine life of her progeny. Heredity has also been put forward as having a bearing on the causation. It may have, but it is difficult to prove so. I have had one very suggestive instance where a father had a right hare-lip, his second child, a boy, was born with a double hare-lip, his third child, also a boy, had a complete right hare-lip and cleft palate, whilst his fourth child was quite normal. It is not necessary to labour the point, but merely to confess that we do not know the why and wherefore of the deformity.

Fortunately, surgery can step in and remedy the defect, with a resulting scar so slight as to be almost unseen.

Most of the remarks which I have made in relation to hare-lip apply equally well to cleft palate, so we pass to—

BRANCHIAL CLEFTS.

A minute aperture on the anterior border of the sterno-mastoid muscle low down in the neck, exuding from time to time a little mucoid fluid, may seem to portend but little, and yet it is evidence of romance in development.

It is the surface opening of the ventral portion of an original gill-slit, and may be said to prove one of the stages through which we have all passed in embryo.

But there is another fascination about it. The inner or deep opening is based upon the mucous membrane of the pharynx above the cricoid cartilage; then why is the outer or superficial aperture so low down the neck as to be near the sterno-clavicular articulation? This is one of the instances which go to show that structures in the neck have been elongated, partly by the growth forwards of the cephalic end of the embryo producing an increase in the length of the neck itself, but also owing to the migration of the cervical structures from the neck towards the thorax.

When a nervous person says her "heart leapt up into her mouth," she is not altogether foolish, for her heart was originally not so very far away from her mouth! It has come to lie in, not descended into, the thorax, with the great vessels. Hence we have the recurrent laryngeal nerves, the common carotid arteries without lateral branches, and possibly even the extraordinary passage of the spinal portion of the spinal accessory nerves into and out of the cranial cavity.

To tackle a brachial cleft fistula surgically is not to undertake an easy dissection, for it is essential to follow the track along its whole length, up between the internal

and external carotid arteries, if the patient is to be rid of the annoyance. I have seen one case of bilateral, symmetrical branchial cleft fistulæ in a young man, the discharge from which was so great as to saturate the upper part of his shirt, causing him to be most uncomfortable. I have seen another case in which a girl had a discharge from a unilateral fistula up to the age of 15. It then ceased to trouble, but at the age of 35 it began to discharge again, and caused her very considerable inconvenience, as she had become a court dressmaker!

To what, again, are we to attribute this failure in the closure of a "gill-slit"? It is highly probable that imperfect peripheral innervation may be an active factor. In connection with this the disfiguring "port-wine" stains not infrequent on the face are interesting, for many of them very faithfully map off the peripheral distribution of one of the divisions of the fifth cranial nerve. To what again are we to attribute the normal failure on the closure of the slits and apertures left for the eyes, nostrils, mouth, vulva, anus and meatus urinarius? Is a nerve influence again at work, and in these instances with a beneficent result?

Congenital Umbilical Hernia.

A true congenital umbilical hernia is a failure of closure in the middle line of the ventral aspect of the abdomen, where "Wharton's jelly" remains. Into this hernia at the base of the umbilical cord extrude many of the abdominal viscera.

So far, surgery has not been very successful in helping Nature to close this gap, but with further experience of operation on the first or second day of life, a greater success may result in the future. Left alone, almost all the victims of this congenital deficiency perish. I have seen one case in which a female infant was born with a large gap in the region of the umbilical orifice, but the "Wharton jelly" became as it were covered with skin, and the child survived, and I have watched its progress, and it is now nearly a year old. By putting the rectus muscles into action, the infant causes its liver to protrude into the sac. When this viscus is "outside" the abdominal cavity, the child is able literally to pat its own liver! The child has also a failure of development of the right upper limb. It is, as is well known, not uncommon to find more than one congenital deformity present in the same subject.

Embryo-Pathology of the Limbs.

Another condition associated with the limbs is that which is termed "intra-uterine" amputations. It is, however, extremely doubtful whether an amputation ever occurs whilst the fœtus is within the uterus. Most of the instances of absence of a part, or even the whole of an extremity, are really failures in development of the periphery. No severed limb has ever been expelled with the child from the uterus. It is improbable in the highest degree for a symmetrical amputation to be caused by an amniotic band, or the umbilical cord, but such a symmetry may and does occur as the result of embryo-pathology. The most interesting peculiarity of the limbs is, perhaps, where a hand becomes a foot, or a foot becomes a hand. In the former the periphery of the anterior limb is pronated and fixed in pronation, and provided with "toes" in place of "fingers."

Sequestration.

Whilst the lateral halves of the dorsal and ventral mid-lines of the body normally come together and join accurately where they should, sometimes an abnormal "infolding" and "sequestration" occurs. Strictly speaking the central nervous system, particularly the spinal cord, is formed in part by a sequestration of surface epithelium on the dorsal aspect. There is an infolding of epiblast with a subsequent cutting off by mesoblast of superficial from embedded epithelium. Hence the spinal cord is a variety of "sequestration dermoid." A failure to complete this separation from depth leads to spina bifida.

Spina Bifida.

Complete spina bifida, or myelocele, is present when infolding has failed and no mesoblast intervenes. This enforces death by loss of cerebro-spinal fluid soon after birth. On the other hand, a meningocele is a less pronounced defect, and may not have a fatal result.

Meningo-myelocele, syringocele and some other varieties show intermediate forms of spina bifida. It is not perhaps realized that everyone present has a spina bifida occulta—in other words Nature has failed, possibly for some good purpose, to close the neural arches of our third, fourth and fifth sacral vertebræ. No inconvenience results, and no meningocele develops, even when the tension of cerebro-spinal fluid is high.

But on the other hand, a lumbo-sacral spina bifida occulta may be associated with an overlying pigmented area of skin, from which depends a tail-like tuft of hairs, and further with double equino-varus, and there is the typical Greek satyr. The freaks of embryo-pathology had a fascination for the ancient mythologists, but what would they have thought of our knowledge of the abnormalities?

OVARIAN "DERMOIDS."

These most interesting examples of congenital "mishaps" should be styled teratomata rather than dermoids, for they contain often more than dermal tissue, and are in reality attempts at embryo-formation. Their origin is still very obscure. At least three suggestions may be made, viz.:

1. The teratoma is derived from an embryonic cell of the ovary of the host, and is therefore a son or daughter of the host, and an attempt at embryo-formation without the male element.

2. The teratoma is included twin, and is therefore brother or sister of the host, this ovum of the mother not having been impregnated.

3. The teratoma is a true sequestration dermoid, being a part of surface epiblast of the host, and therefore part of herself, and of the same generation.

Whilst practically all the tissues normally present in the human being may be seen, though very imperfectly developed, yet structures derived from epiblast are most frequent and most developed.

Hairs are very common, and sometimes of a yard in length, though more often "shingled." In connection with them their colour is interesting. Does this colour conform to the colour of the hair of the host, or is it totally different?

Does the raven-black-haired woman have an ovarian teratoma with auburn-coloured hair, or *vice-versâ*? Further investigation on this point and its bearing on the ætiology of these teratomata is needed.

INCLUDED FŒTUS.

A true included fœtus or sequestrated twin does occur, but it is very rare. I have had one instance under my observation in which I did a "Cæsarian section" on a boy aged 7 months, and delivered him of a dead fœtus which had been suspended in an amniotic sac from the front of the second lumbar vertebra. It possessed a head, with hair, rudimentary limbs, an umbilical cord, and vernix caseosa.

The boy survived, and is now several years old, and a sturdy young Briton, who will probably remain in ignorance of having been a celebrity in relation to fœtal pathology!

INTESTINAL ABNORMALITIES.

The romance of the abdomen in relation to the development of parts of the intestine is distinctly fascinating. The very formation, rotation, and migration of the alimentary tract during intra-uterine life is full of mystery.

Why does the stomach rotate so that its right surface becomes dorsal and its left ventral? Why does the cæcum pass across the abdomen and *upwards* into the right iliac fossa, the fœtus being upside down in the uterus during this period of migration?

Then there are the extraordinary examples of arrest in the formation of parts of the intestine.

The stomach may be well formed and the duodenum normal, and then a gap, so that there is no continuity between duodenum and jejunum, and the child dies soon after birth of intestinal obstruction. Congenital enlargement of the colon-megacolon is another of these curious embryonic abnormalities. It is certainly possible that the intestinal imperfections are due to faulty innervation of the affected segment of the bowel, or of a want of perfect vascular supply at this spot.

CONCLUSION.

Time does not permit of further investigations into this fascinating subject, but before leaving it I would urge that it is by study of the abnormal that light is sometimes thrown upon the definite causation of the normal, the exception again perhaps proving the rule. We live in a world of the forces of hormones and vitamines, and we know not what the next generation may be able to piece together of the intricate processes of our development. Already we are showing that there is possibly a vitamine of reproduction. In fact a fat-soluble vitamine E is said to have been found in the ether extract of wheat embryos, in lettuce-leaves, and in some fruits. Sterility is, of course, a very wide subject, but what if some reason for it is to be found in the absence of vitamine E?

Some experimental work has already been done on this line. Some heifers which failed to become in calf on certain dried foods readily became pregnant when mated after a month's diet containing sprouting oats. The explanation given is that either the sprouting oats contained some essential vitamine, or that they acted as a substitute for the spring-grass which coincides with the natural breeding-season of most animals. And what of hormones? Most hormones certainly affect the body generally, but some have a peculiarly selective action, and certain masses of developing cells are ready to be acted upon by them.

It is therefore quite legitimate to assume that hormones derived from mother or from fœtus really play an important part in the proper development of the child *in utero*, and that the absence of hormones, or their want of proper correlation and co-operation, may result in some of the manifestations of embryo-pathology which have so much romance and are so fascinating.

W. MCADAM ECCLES.

SOME COMPLICATIONS OF ARTIFICIAL PNEUMOTHORAX TREATMENT.

THE successful results of artificial pneumothorax treatment and the ease with which it can be carried out in suitable cases have encouraged many to undertake it, and there is a laudable tendency for the general practitioner to make an "A.P. box" part of his equipment. Every case, however, requires a great deal of individual thought, so that if rule-of-thumb methods are applied, a number of substantial rocks will be struck before very long. By a fair knowledge of the rules of the game as set forth in books, it should be possible to steer pretty clear of such immediate complications as pleural shock, surgical emphysema, air in vessels or lung cavities, and sepsis; or even of more insidious mishaps, such as the spread of an unexpected focus on the other side, or the numerous disadvantages attendant on a too much raised intra-thoracic pressure. At any rate, these have been all fully and often described; it is in the unsatisfactory cases, those with adhesions, where the lung will not collapse, those which develop fluid, so that the lung will not expand again, that there are points of interest to be here discussed. And the first essential to be stressed in these cases is a frequent X-ray examination—ideally before every refill, practically at least once a month. The observance of this rule is one of the chief difficulties in tackling the matter in general practice. Naturally an initial X-ray is always done, since it is widely known that only one-third of the disease area which would be discovered post-mortem is, on an average, to be elicited by physical signs.

Fibrosis.

This deterrent factor is suspected in a long-standing case with periods of remission or where a history of pleurisy has been obtained. It is shown in a skiagram as a general smoky appearance with a thick line in the position of the interlobar septum, and in advanced or basal cases by a cone-shaped or "tented" diaphragm. The physical signs do not give any idea of the extent of the process, but the percussion note and the air-entry are the most valuable. If it is decided to attempt an A.P. in spite of all this the position is determined partly by going in over the most resonant part. Very often the only place to be found is in the second or third space in front (care being taken to avoid the subclavian vein) but any site may be chosen. While one would never anticipate anything like eradication of the disease in such a case, yet the patients temperature may be made to settle for a time, his sputum and cough to diminish, and, above all, he feels there is something being done for him.

When the fibrotic process is not advanced, after half a dozen refills an X-ray will often show a small group of adhesions which are holding the lung out in one place (Figs. 1 and 5). The commonest type met with, because perhaps the easiest to be photographed, is that in which the adhesion stretches towards the third or adjacent ribs in the axilla. The apical part of the lung tends to become collapsed first, partly because the process is usually more active there, partly because air tends to rise; but of course it is common enough to find a basal collapse only, and sometimes basal adhesions are very hampering.

Apart from the skiagram these adhesions are suspected both by hearing breath-sounds over an area which one would expect to be collapsed, and also during the process of re-filling, by finding that small quantities of air will raise the pressure very quickly, that air goes in slowly and has to be forced in under pressure, and finally that it will only go in at all over certain areas. Thus in one case the point of the needle would come up against a taut adhesion; below this situation air could be inserted, but not above.

Thoracoscopy.

Having located the cause of the hold-up, thoracoscopy and division by cautery is to be considered. For this purpose refills are given at frequent intervals (every two days) for the purpose of stretching the adhesion and getting a maximal collapse. Care is taken to keep a keen watch on the position of the apex-beat, for instead of stretching adhesions one may merely be pushing the heart and mediastinum over—a useless occupation, and one which hampers the respiration of the patient's sound lung.

Case 1 illustrates how the prognosis may be completely altered by the successful division of adhesions.

Girl, æt. 15, admitted November 15th, 1926, with 3 months' history of cough, loss of weight and anorexia. X-ray on admission showed marked fibrosis and softening in upper and middle zones, and infiltration of the lower zone on the left side. There was commencing infiltration at the right apex also.

November 22nd, 1926: L.A.P. induced, but the refills had to be made smaller and smaller (about 200 c.c. only, twice weekly), the mean final pressure being +2. The sputum was still T.B. +; there was an intermittent pyrexia in spite of the fact that the patient was on absolute rest. Fig. 1 shows the condition at this time.

Chart 1 shows a common indication for a refill—a rise of temperature, which is lowered at once when the air has been given. The general and local condition thus demanded an interference.

On January 11th, 1927, thoracoscopy was done and three adhesions divided. From that time the patient remained completely afebrile, although up 4 hours a day. Examination of sputum for tubercle bacilli on February 7th, 1927, was negative, and the X-ray Plate II shows almost complete collapse. Occasional refills were subsequently given.

The technique of thoracoscopy has been described in a number of recent papers; it will therefore only be necessary to make one or two comments. The posterior operation is most generally used, the thoracoscope being inserted near the angle of the scapula, with novocaine infiltration, which takes in the nerves of three intercostal spaces; the optical part is turned upwards to avoid being smeared with blood, and a good view is obtained of the pleural space. The shining air-vesicles with their red blood-vessels and the glittering white of the stretched adhesion form a noticeable contrast. An adhesion which contains lung-tissue or which is very vascular cannot be divided, and watch is kept for any small adhesions which might give way when the main one is cut.

Having located the adhesion the cautery-knife is inserted through a new infiltrated area, usually near the fifth intercostal space in the anterior axillary line, until it comes within range of the thoracoscope. The knife is brought to a dull red heat and the adhesion cut as far as possible from the lung. Since a considerable amount of smoke is developed in the pleural space which might lead to pleurisy and effusion, this is cleared away by replacing the thoracoscope with the metal tube provided, the patient's respiration performing the necessary pumping and suction.

Cotton-wool pads and tight strapping will prevent surgical emphysema. The patient lies on the non-operated side when returned to bed, so as to keep the severed ends of the adhesions apart.

Complications which might follow the operation of cauterization are pleural effusion, spontaneous pneumothorax and hæmorrhage. The last can be avoided; with the second we have now to deal.

Spontaneous Pneumothorax.

Case 2 illustrates the second of these complications.

A. R—, male, æt. 23, admitted December 1st, 1926, with 5 months' history of repeated hæmoptysis. Sputum T.B. + December 7th, 1926.

December 7th, 1926: Initial R.A.P. As in Case 1, the pressure tended to become positive after small refills; there was intermittent pyrexia and the sputum remained T.B. +.

January 7th, 1927: Thoracoscopy was performed, two adhesions being divided, but the lung was not evidently much more collapsed. Artificial pneumothorax treatment was continued. (Fig. 3.)

February 4th: A second thoracoscopy was performed. A number of vascular adhesions were seen, which were too closely related to the lung to be cauterized. One large band was divided.

At 1 a.m. on the night of February 5th patient was seized with acute pain at the right base and was very dyspnœic. Temperature 100°, pulse 120, respirations 28 (Chart 2).

February 6th: The apex-beat was in the mid-axillary line. The percussion note was hyper-resonant all over that side; the breathing was amphoric and a coin sound obtained all over right side. The chest was explored in the axilla, and air came out under pressure; the needle being left in for 5 minutes. A tight bandage was applied.

February 8th. Fluid splash heard right base.

February 10th, X-rayed (Fig. 4).

February 14th: Fluid at level of sixth rib in mid-axillary line.

February 16th: Pressure taken, + 5, — 2.

February 23rd: Chest explored. Dark hæmorrhagic fluid obtained. Pressure + 6, — 2.

February 23rd: Air replacement. 32 oz. hæmorrhagic fluid drawn off. 350 c.c. air put in. Final pressure + 3, 0.

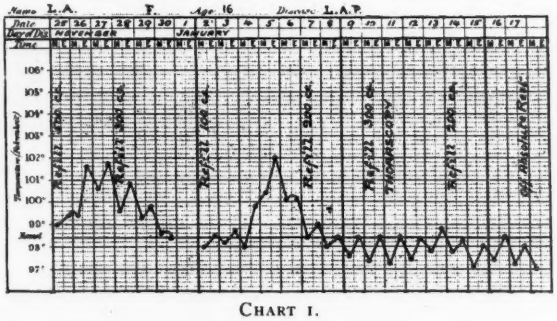

CHART 1.

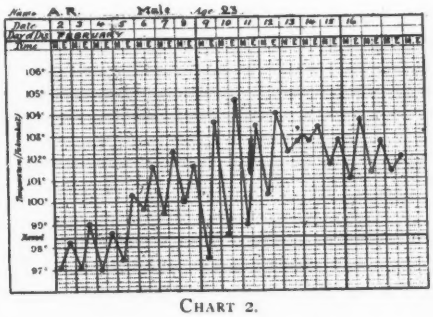

CHART 2.

March 3rd: Sputum T.B. negative.

March 29th: Air replacement. 62 oz. of fluid (as before) removed. 900 c.c. air put in. Final pressure + 1, + 7.

April 3rd: Temperature settled. Patient comfortable; effusion still present.

April 13th: Patient up 2 hours on couch.

May 3rd: Patient still apyrexial. Discharged to sanatorium.

This case is a good example of the course and treatment of a spontaneous pneumothorax. The initial attack of pain was probably due to the giving way of one or more of the adhesions seen during thoracoscopy; the signs of collapse of the lung and the pushing over of the heart are indications for taking the pressure and removing as much air as will make the patient comfortable. The persistent hæmorrhagic effusion indicates air-replacement.

CASE 3.—A similar case of right spontaneous pneumothorax occurred as the result of infection of a pleural effusion, causing a pyopneumothorax. On admission some weeks later to the Brompton Hospital the temperature had settled, but the mediastinum was well over to the left and the patient's condition far from comfortable.

1100 c.c. of air were removed by means of the A.P. apparatus, the patient being X-rayed before and after. Unlike the majority of cases where removal of the air succeeds in drawing over the mediastinum, it is remarkable that here the X-ray showed no change.

There being, after a fortnight, no signs of re-expansion of the lung, the patient had an extra-pleural thoracoplasty performed in two stages, and so far has done very well, though it is far too early to judge of the final result.

Chart 3 illustrates a third case of spontaneous pneumothorax.

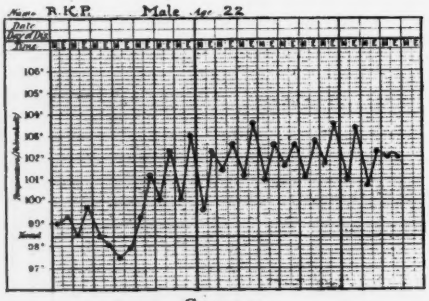

CHART 3.

CASE 4.—R. K. P—, male, æt. 22, started to be ill in March, 1925, and after two attempts an L.A.P. was established in October, 1925. Was readmitted to Brompton Hospital five days after a refill with acute pain in the side and a temperature of 103°. Was explored on a number of occasions, the fluid being at first sterile and serous, but by January 4th, 1927, had become purulent and contained tubercle bacilli. The culture was still sterile. The fluid was twice air-replaced, but it was not until a wash-out with Gauvain's solution 10 c.c. was employed that he became apyrexial. Though the fluid has persisted the patient has been pretty fit, up all day, and there were signs of re-expansion of the lung in March. Should the lung not come out, a thoracoplasty would have to be performed.

Pleural Effusion in A.P. Cases.

Animal experiments have shown that the production of a pleural effusion is dependent on two factors—pressure changes, and damage to the pleural endothelial cells. The actual pressure changes are not fully understood, and there is probably some variation for different individuals. It is seldom possible to predict or control the formation of fluid, though one expert is at present producing fluid in certain cases to obtain a collapse which has not been effected by air alone. In several cases an effusion has followed a series of large refills, and has also depended upon intercurrent infections, such as coryza and influenza, as well as on a long journey or hard work. It frequently happens, however, in in-patients under observation that none of these factors are present. The rapidity with which the air is inserted is also important; and many continental authorities object to the large Clive-Rivière and Saugman needles in use over here. With their small needles they need only use novocaine for the initial.

The onset may be accompanied clinically by great constitutional disturbance (Charts 4 and 5), or it may be so insidious as to give no signs until the X-ray shows a definite level. This difference will, of course, largely depend upon whether the lung is already for the most part collapsed, or whether this collapse has to be brought about by the positive pressure occasioned by the fluid, which tears the adhesions that attach the visceral pleuræ to the parietes and, as has been stated, sometimes contains lung-tissue. Some maintain that there is a localized spontaneous pneumothorax with rupture of lung-tissue in every case of this sort, but this is probably not true,

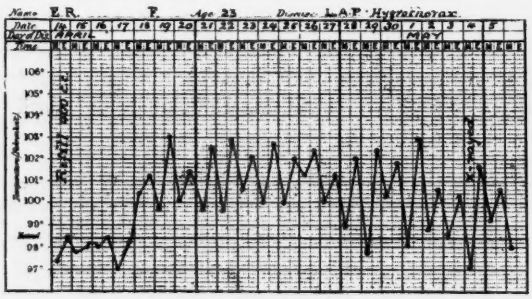

CHART 4.

because there is rarely blood to be discovered in the effusion, and because recovery is much more speedy than with spontaneous pneumothorax.

Be this as it may, the onset of fluid is decidedly suggestive of the more serious condition, as evidenced by Charts 2, 3, 4, and 5, which are given for comparison. In rupture of the lung the evening pulse is usually over 120, with respirations of 30–40, while in hygrothorax these do not usually go above 100, 26. The rise of temperature, often accompanied by vomiting, and always by headache and pain referred to the shoulder or to the lower ribs on the same side, usually occurs from two to three days before any signs of fluid can be detected.

Contrast this stormy type with that in Chart 6—a case where there was already fair collapse (Fig. 5). This adhesion was rather unexpectedly responsible for a persistent pyrexia of about 100° over several weeks with T.B. + sputum and night sweats. One evening the patient felt a splashing sensation in the right chest and on examination next morning there was a slight but definite fluid splash, but no other signs and no symptoms. The temperature is settling, possibly owing to compression of the adhesion, possibly to the concurrent sanocrysin treatment.

The first physical sign commonly elicited is the fluid splash obtained by shaking the patient during auscultation (and accompanied by a palpable thrill when

Fig. 1.

Fig. 2.

Fig. 3.

Fig. 4.

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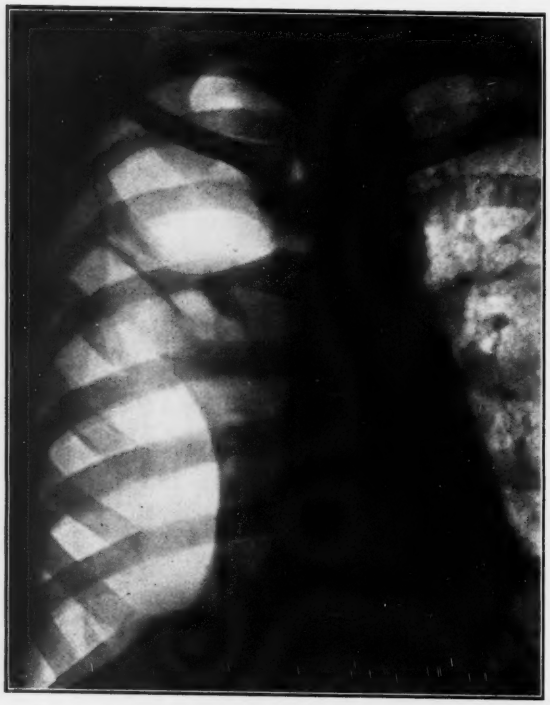

Fig. 5.

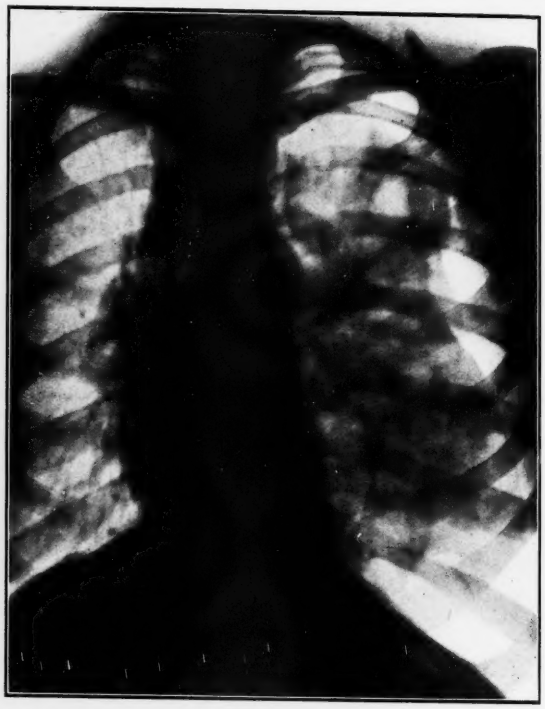

Fig. 6.

Fig. 7.

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there is much fluid). This is a most reliable sign, and can always be found unless the fluid is very encysted and not likely to be discovered with the exploring needle. With this are the signs of further collapse of the lung—diminished or absent air-entry, amphoric breathing and a coin sound, as well as a hyperresonant percussion note and absent focal fremitus (the voice-sounds may still come through). The coin sound is very useful also in determining the exact level of the effusion (the importance of which is described later), where percussion is indecisive owing to thickened pleura. The position of the apex-beat is not, as in spontaneous pneumothorax, to be depended on; where the heart is definitely pushed over it naturally gives useful corroborative evidence, but it is surprising how often there can be a good-sized effusion—say up to the fourth rib in the axilla—without alteration in position of the apex-beat, the heart being either tethered by fibrous tissue or drawn over by the lung collapse. The point is sometimes important in the differential diagnosis of the two conditions.

As every text-book says, the chief indication for removal of fluid is cardiac embarrassment, as evidenced by dyspnœa, pain, rapid pulse, or a diffuse cardiac impulse with heaving beat. Since in most cases the fluid is performing useful work by keeping the lung collapsed, it is usual to leave it when possible after exploring for pathological investigation. If it is found necessary to take some of it off it is probably better to gas-replace it, because otherwise adhesions will form and further A.P. treatment be out of the question. For this purpose air is usually good enough; but some use nitrogen, which is more slowly absorbed, and in cases with cyanosis or marked dyspnœa oxygen is often of value. Where gas is used the calibrated A.P. bottle is first filled from the cylinder with the manometer of course clipped off.

A very convenient method where the fluid is purely serous and one does not want to make two holes in the patient, is to attach the tube of the Potain or Burrell's aspirator to the spare limb of the A.P. needle, a Spencer-Wells being used to clip off the A.P. apparatus, so that fluid does not run into and block the air-filters. As this side-tube is of fine bore this method cannot be used if the fluid is thick, and it also requires some practice in hitting the right level, so that fluid can be removed with the point of the needle depressed, and air inserted when the point is raised above the fluid level. Hence, then, the value of getting the exact level by coin sound or other means.

That fluid has its uses is well shown in Figs. 6 and 7, where, in a girl æt. 24, about a dozen refills had hardly effected any collapse, the patient being febrile, with T.B. + sputum and progressive loss of weight. Further, it was becoming increasingly difficult to maintain a negative pressure, so small was the space (Fig. 6). The climax was reached when the initial pressure was + 4, 0, and no air was put in. A positive pressure like this is suggestive of the onset of an effusion, and within a week there occurred the usual syndrome, with pyrexia shown in Chart 4. That a very successful collapse was obtained is shown in Fig. 7.

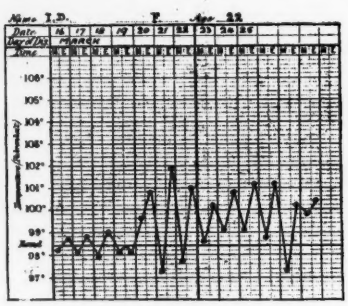

CHART 5.

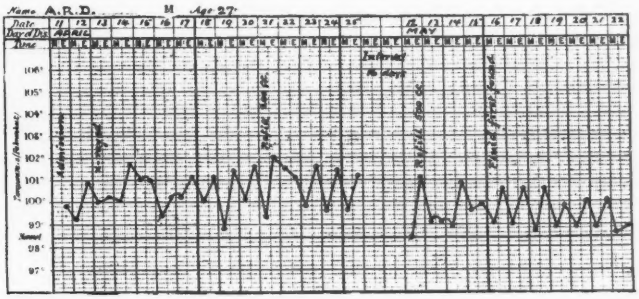

CHART 6.

The main danger due to effusion is that in a number of cases the fluid persists and the lung can never be made to come out again. The best course, then, is to improve the patient's general condition (they are usually very fit at this time) by three months' sanatorium treatment and then to do a 2-stage thoracoplasty. At least three cases recently treated at the Brompton Hospital have done very well, while those that are left appear invariably to get a tuberculous pyopneumothorax generally within the year, and then their condition is hopeless. A sure guard against this is the presence of an apical adhesion, such as that shown in Fig. 6, which gives just that amount of air-entry necessary to start re-expansion. Hence the importance of the remark made

above that cauterization should not be adopted unless the patient's condition definitely demands it.

Perhaps there is more in artificial pneumothorax treatment than meets the casual eye.

I am indebted to Dr. L. S. Burrell for permission to publish these cases. F. C. ROLES.

PATERNITY AFTER PROSTATECTOMY.

FERTILITY after prostatectomy is a very rare event. Suprapubic enucleation entails the destruction of the ejaculatory ducts and the disorganization of the ejaculation reflex. The fact that prostatic secretion is no longer added to the secretion of the testicle is of secondary importance to the anatomical injuries inflicted by the operation. Experiments on animals, and notably on the rat, have shown that neither fertility nor virility are destroyed by depriving the animal of prostatic secretion, for in the rat the prostate gland can be removed without disorganizing the act of ejaculation. But in man the intimate relationship of the prostate with the neck of the bladder and the posterior urethra prevents its removal without inflicting grave injury on the latter structure.

On looking up records of the subsequent histories of prostatectomized patients one finds that as a rule the sexual act is very little impaired by the operation. Thomson-Walker states that he found no alteration of sexual power in 67·5% of patients he had submitted to suprapubic prostatectomy. In 20% a gradual loss of vigour occurred, and a complete abolition of the sexual function was only found in 12·5%. But if we question these patients further as to any alteration that they may note in the performing of the sexual act after the operation we find that at the climax of the act ejaculation is absent. Instead of being thrown out of the urethra at the moment of orgasm the secretions pass back into the bladder, and are voided in the urine when the patient subsequently micturates. Theoretically it is possible that a small amount of testicular secretion should escape, and that this secretion, if it contains spermatozoa, might result in a pregnancy. But actually the occurrence of a pregnancy is the very rarest event. For this reason the notes of a case operated upon in June, 1925, in St. Bartholomew's Hospital who two years subsequently had a child is of some interest :

Mr. X—, æt. 48, was admitted in May, 1925, with symptoms of an enlarged prostate and partial retention. His symptoms dated from eleven years previously, when he had first commenced to get up at night to pass urine. At the time of admission his bladder contained 1½ pints of residual urine, the prostate when felt *per rectum* was definitely enlarged, and cystoscopy showed an intravesical projection. After a period of drainage through an indwelling catheter suprapubic prostatectomy was carried out by Mr. Harold Wilson. Convalescence was uneventful, and the patient was discharged on August 14th, 1925. Sexual vigour was not impaired by the operation. Previous to admission the patient's sexual appetite had led to domestic difficulties, and even to public scandal, and his subsequent behaviour does not appear to have been changed by his sojourn in St. Bartholomew's Hospital. Eighteen months later the patient's wife consulted a doctor, her suspicions having been aroused that she was pregnant. She was told by her medical adviser that this was extremely unlikely in view of her husband's operation. Two months later the question of pregnancy was no longer in doubt, and subsequently she was delivered of a healthy child.

The sceptic is justified in exclaiming that the above history is no definite proof of fertility following prostatectomy, but although there is truth in the adage that "It is a wise child that knoweth its own father," there is collateral evidence to support the view that the patient was actually the parent of the child in question.

In the experience of others I have only been able to find one similar case—a patient operated upon by Mr. Swift Joly, in St. Peter's Hospital. In this case additional evidence of paternity existed in a reputed likeness between father and child.

I am indebted to Mr. Harold Wilson for his courtesy in allowing me the use of his notes.

KENNETH M. WALKER.

THE LIGHTER SIDE.

THE Asiatic dresser is not the homologue of the English one; he is in the position of a male nurse in a native hospital, but is expected to become rather more skilled in diagnosis and treatment than a nurse, for on occasion the care of a small out-station hospital may devolve on a senior dresser.

In Malaya dressers are Tamils and other Indian races, Malays, and Chinese, Tamils predominating. Their training, therefore, is carried on in, what is to them, a foreign language, although they are not accepted as probationers without a moderately high English school certificate.

When the time comes round for the promotion examinations it requires a great deal of patience to sift and mark the ideas and knowledge which, at least in the junior grades, may be concealed under a flow of apparently disconnected words. The expressions frequently show signs of having been crudely translated from the vernacular, such as the following answer to a question on post-anæsthetic care :

"The main danger after vomiting are the patient pulse feeble and fever will collapse. I will make hot

water bottle apply the body through the blanket. The patient head must be law. I must watch him untill he rise up: dont give him any solid food before he wake up: only can allowed a cup of tea water."

Other anæsthetic questions elicit the following information:

"Stimulent stage the patient will be just like as taken a dose of brandy, and will be talking and shouting and telling bad words."

Another candidate states that, in the first stage, the patient "hears a music nose (noise) in his ears."

At first glance the following essay on the knee-joint appears to be nonsense, but it contains certain glimmerings of ideas which must be credited in proportionate marks:

"The Hinge joint or Knee joint its forms the Patella joint, the structure of this as it contains the synovial fluid which lubricates and moistens the joint so we can move it to all parts freely. So its main action is it is a Flexor, Extensors, Abduction, can be freely given to it. And it articulates below Downwards by Tibia and Fibula bone and upwards by the Femur, so main artery passes behind it is Femoral artery."

All too often, however, a stream of misheard words and imperfectly memorized phrases are used to cloak ignorance. What can the candidate have understood by this? "Gangrene is a cellur deth of tisue ending in masses."

Or this: "The dead part tissues in masses."

One expert adds the gratuitous information that "Gangrene of bone is called Narcotics."

The meaning of words in common use is strangely misunderstood. "Aspiration" is usually interpreted as "breathing," but one candidate strikes out a new line. "Aspiration," he says, "is the term applied, when a thing goes down to its normality." "Military" and "biliary" tuberculosis are favourite perversions. "Prostruction" and "flatulation" are of new coinage. "Fibia and tibula" I find is *not* a slip of the tongue.

The spleen seems to have been the subject of much teaching, with the following results:

1. The spleen is the torax organ, weighs about 18 lbs.
2. The spleen mends up the broken corpuscles.
3. The spleen replaces old red corpuscles with new white corpuscles.
4. The spleen Describe weak the body the Patient getting every day Fever.

Other gems, collected over some years, are the following:

"A patient is suffering from Malaria and by the help of microscope some Parasites are invented in his blood."

"Mag. Sulph. constipates the vowels."

"Fluctuation is the symptom of inflammation. It is a doughy soft tissue. When we press on it it jumps as like as a rubber filled with water."

"The action of Potassium nitrate is to give dilate the cornea of the eyes. The action of Potassium Bromide is to give sleeping sickness or in the case Epilapic."

"Empyema: Some surgeons do resurrection of the ribs."

"Pulse Hæmorrhage of the artery is scarlet colour. Spurring." (This in answer to a question as to the effect of hæmorrhage on the pulse-rate.)

"Lacteals are the Vegetable Kingdom's Drugs, it is a Carminative. It has an action to Digest our food, so it is best Renown in the vegetable Drugs."

"Hæmorrhage of a crushed foot can be arrested by ambutation."

Intravenous saline is given "prior to fatal termination of diseases."

As first aid for a compound fracture one dresser "gives him more ventilation."

In the oral examinations the dresser's flow of words is checked and he endeavours to answer each question in one word, generally choosing the most abstract possible.

Suppose you ask your candidate to describe the process of inflammation; you will probably get a silent stare. This need not indicate complete ignorance, and you must persevere: "What happens in a septic wound?" Light dawns and he may answer, "Inflammation." On further pressure he may ejaculate, "Leucocytes," "congestion," and so on. As he refuses to put two words together, the assessment of his knowledge is not easy.

Showing a few simple instruments gives rise to some amusement (to the examiner) in this way. The arrangements being somewhat primitive, the waiting candidates are able to learn from the earlier batches what instruments are on the table—at least in the opinion of those who have been asked to recognize them. Names are passed on from one to another without any further means of identification, and crop up again and again in more and more garbled form. One candidate recognized "bone-forceps." A little later another fitted the name on to a totally different forceps and was not informed of his error. A third came out boldly and promptly with "Bowman's forceps"!

Again, a tracheal dilator was identified by one man. For some time after, every impossible instrument, from sponge forceps to aneurysm needle, was being spotted as "tracheotomy retractor."

Any lead is eagerly seized upon and sarcasm is not understood. Here is an instance:

Examiner: What do you mean by the reaction of the pupil to light?

Candidate: Reflects.

Examiner: No, no! What is the effect of light falling on the pupil?

Candidate: Moves.

Examiner (exasperated): Moves how? Sideways?

Candidate (eagerly): Yes, sir!

In justice to dressers as a class it must be admitted that such light relief as this is not sufficiently frequent to render examining a pastime.

T. W. H. B.

ABERNETHIAN SOCIETY.

SUMMER SESSIONAL ADDRESS.

THE first ordinary meeting of the Summer Session was held in the Medical and Surgical Theatre at 8.30 p.m. on Thursday, June 23rd, 1927, Mr. Wroth (President) in the Chair. The minutes of the last meeting were read and confirmed.

The PRESIDENT then introduced Lt.-Gen. Sir MATTHEW FELL, K.C.B., C.M.G., as Director of His Majesty's Army Medical Services and as a "Bart.'s" man, and called upon him to deliver his address on "Casualties."

Sir MATTHEW FELL commenced his lecture by outlining the position of the British Army doctor, which is, for several reasons, unique. One of these reasons is the absence of conscription from the British Army system.

The Great War had been responsible for much development in the Army Medical Service: at the end of the war the personnel of the R.A.M.C. alone was greater than that of the entire British Expeditionary Force of 1914.

With this introduction the lecturer proceeded to trace out the history of the Army doctor and the ambulance. He defined three periods: the first, including prehistoric times, up to those of the Roman Legion; the second, from the Roman Legion to the Crusades; and the third, on to the Napoleonic and later national wars.

Æsculapius himself, the Father of Medicine, seems to have been a naval surgeon, but his two sons, Machaon and Podalirius, were doctors in the army which besieged Troy.

In the Roman Legion, the medicus of the cohort, who was usually a foreigner from Spain, Egypt or Iberia, was an important personage. Memorial tablets to several Roman army doctors have been found near York.

Little is known of the medical arrangements at the time of the Crusades, beyond that ladies were in the habit of presenting their knights with simples. In the Last Crusade the Christian armies were badly attacked by scurvy. Many of the knights assumed the functions of doctors and nurses, and called themselves Knights Hospitallers.

There was a definite number of doctors at the battle of Crecy; at Agincourt they were mentioned in the battle roll, but they were classed among the camp-followers, along with shoe-makers, tailors and washerwomen.

A "Bart.'s" man was a naval surgeon with the Spanish Armada, and acted as an army doctor at the battle of Zutphen.

Another Bart.'s man, Thomas Gale, was the author of the first book on gunshot wounds.

Under the Stuarts, especially Charles II, the army and its medical service became better organized. Chelsea Hospital was founded by Charles II for wounded soldiers. Every company in the army had its own barber-surgeon.

At Blenheim, Ramillies, Oudenard and Malplaquet hospitals went with the army, but there were no arrangements for moving the wounded from the field to the hospital.

In the middle of the eighteenth century two important books were written by army doctors. One, by John Pringle, was described as a "Bible of Hygiene." Pringle gained his experience in Flanders and with the Duke of Cumberland's expedition against Prince Charlie. The second book, by Donald Munro, Senior Physician to St. George's Hospital, was particularly interesting in that it laid down an organization for women nurses. This was nearly a century before Florence Nightingale. According to Munro, nurses should be subject to the same discipline as the soldiers; they were liable to be whipped or court-martialled for such offences as drunkenness and stealing.

In 1759 John Hunter was Deputy Surgeon-General to the Forces.

In the next century were the Napoleonic Wars. By this time doctors and hospitals were regularly attached to the army, but there were still no field units or transport arrangements for the wounded. The Duke of Wellington refused to be encumbered with ambulance wagons. There were no nurses; the wives of many of the soldiers followed them and looked after them when they were wounded.

A surgeon under the Duke of Wellington, Guthrie, later became President of the Royal College of Surgeons. Most of the accounts of the treatment of the wounded were obtained from private diaries.

Thus, Charles Boothby wrote a description of his experiences at the battle of Talavera, when he was shot in the ankle.

In *Fry's Diary* there is an account of Waterloo. In 1815 Fry was doing the Grand Tour; he arrived in Brussels just before Waterloo.

The battle was on June 18th at a spot twelve miles from Brussels. On June 22nd Fry drove out to see the battle-field. He wrote a vivid description of the dead and dying. Hundreds of wounded men remained on the field for many days after the battle, dying of hunger and thirst and of their untended wounds.

In the Crimean War wheeled transport was introduced as an experiment. The writings of a Frenchman named Dunon at this period laid the foundations of the Red Cross movement.

In the Franco-Prussian War it was realized for the first time that immediate assistance to the wounded was a means of conserving man-power; after this, the whole system of medical aid was re-organized.

Sir Matthew Fell then showed some lantern-slides illustrating the activities of the medical services during the Great War. Over 4,800,000 sick and wounded men in the British Army were returned to duty.

The Roll of Honour of the R.A.M.C., which is to be seen in Westminster Abbey, includes 743 officers, of whom 90 were regulars, and 6130 warrant officers, N.C.O.'s and men.

The lecture concluded with some lantern-slide views of Gallipoli—the worst of all the fronts from the point of view of casualties.

Sir CHARLES GORDON WATSON proposed a vote of thanks to Sir Matthew Fell for his very interesting address. He mentioned their close association together at the Hospital and during the South African War. In the course of thirty years Sir Matthew Fell had ascended to the very highest place in the medical world; moreover, he was the first Bart.'s man to occupy the post of Director of the Army Medical Services. Sir Charles hoped that more Bart.'s men would go into the R.A.M.C. to carry on the tradition.

Mr. SCOVELL seconded the vote of thanks in a few well-chosen words. He told an amusing story of a Roman centurion whose empyema was drained by a spear-thrust in battle.

The PRESIDENT then adjourned the meeting.

E. T. C. SPOONER.

STUDENTS' UNION.

CRICKET CLUB.

ST. BARTHOLOMEW'S HOSPITAL *v.* STOICS.

June 1st. This match resulted in a win for the Hospital mainly owing to the very fine bowling performance of Bettington, who took 8 wickets for 49 runs.

The Stoics, batting first, were dismissed for 89.

The Hospital made 135, chief scorers being: Mackie, 44; Bettington, 39; Patrick, 23.

ST. BARTHOLOMEW'S HOSPITAL *v.* HAMPSTEAD.

Saturday, June 4th. The Past *v.* Present match was postponed till July 9th, and a last-minute fixture with Hampstead provided a very interesting game which ended in a tie.

Hampstead, batting first, made 172. The Hospital, after losing the first wicket without a run being scored, recovered owing to the

steady batting of Cook and Mackie, who made 56 and 44 respectively. The next few wickets fell without the addition of many runs, but the last three batsmen brought the score level.

ST. BARTHOLOMEW'S HOSPITAL *v.* CROYDON.

Monday, June 6th. Being Whit-Monday, many of the regular team were away, and it was unfortunate that such a weak team represented the Hospital against a full Croydon team.

The Hospital, batting first, made 88. Cook 32, Stanton 17, O'Connell 15 were the chief scorers.

For Croydon Rowbotham made 94, being out to a very good catch by Gaisford.

He played a very sound and forceful innings, and was unlucky not to make his century. As the Hospital had a strenuous week ahead stumps were drawn when Croydon had lost 5 wickets, having scored 197.

ST. BARTHOLOMEW'S HOSPITAL *v.* ST. MARY'S HOSPITAL.

Second Round Inter-Hospitals Cup.

This match was played on St. Mary's ground at North Wembley on June 7th, and resulted in a win for Bart.'s.

Bart.'s, winning the toss, went in to bat. Parker, who went in first with Cook, was run out when the score was only 7. Bettington joined Cook, and all seemed to be going well when Bettington was out to a catch at point, the ball having got up very quickly. Sinclair and Cook then stayed together for some time. Sinclair at once began to hit the bowling, and the score crept up to 48 when Cook was caught. Patrick had a short but lively innings, making 23 in a few minutes. Sinclair was still at the wicket and scoring rapidly, when he, too, fell to the vagaries of the pitch, and was caught, having played an extremely good innings for 38 runs. O'Connell batted well, making 27 and was not out. Bart.'s made 155.

St. Mary's went in to bat, and when the first wicket fell with only 3 runs scored and the second for 10 runs, things looked hopeful. Wright and Harvey were the only ones to offer any resistance to the bowling, each scoring 14 runs. St. Mary's were all out for 78.

In winning this match we enter the semi-final, when we meet St. Thomas's.

ST. BARTHOLOMEW'S HOSPITAL *v.* U.C.S. OLD BOYS.

Saturday, June 11th. The Hospital won the toss and went in to bat. Capper soon lost Cook and was joined by Mackie. Wickets fell rapidly, and 8 wickets fell for 113 runs. Mackie, who was still at the wicket and scoring rapidly, was joined by Hodgkinson. The partnership produced 70 runs, and took the score up to 186 when Hodgkinson was out. Mackie was then joined by Stanton, and Mackie, who had gone in first wicket, was caught after making 105. His innings was without fault and a great help to the side. With 213 runs to get the U.C.S. Old Boys went in to bat. When Cook bowled Morley in his first over victory for the Hospital seemed certain, but owing to a ninth-wicket stand the Old Boys forced a draw, having scored 182 for 9 wickets.

Result: Draw. St. Bart.'s, 213; U.C.S. Old Boys, 182 for 9.

ST. BARTHOLOMEW'S HOSPITAL *v.* R.A.F. (Uxbridge).

Wednesday, June 15th. This match resulted in an easy win for the Hospital. Uxbridge, batting first, were dismissed for 93, Bettington and Cook each taking 5 wickets.

Bettington and Cook opened for the Hospital. Bettington soon mastered the bowling and hit freely, hitting three 6's, many 4's. Cook was batting well, but slower. Before they were separated the score was 151. Bettington made 105 and Cook 62.

The final score was 222 for 7 wickets.

ST. BARTHOLOMEW'S HOSPITAL *v.* ST. ANNE'S C.C.

Saturday, June 18th. The Hospital lost the toss and fielded first. O'Connell and Hodgkinson bowled throughout the innings, each taking 5 wickets, and dismissed our opponents for 89 runs.

The Hospital's batting was opened by Mackie and O'Connell. O'Connell was soon out and was followed by Gaisford, who was bowled after hitting two very fine 6's. After this bright innings our wickets fell quickly, being all out for 69.

The Hospital again went out to field and dismissed their opponents for 52, Taylor taking 5 wickets and Mackie 4.

The Hospital went in to bat with 72 runs to get, and with an hour to get them in. Mackie and Williams opened and forced the pace, and in 20 minutes had made 40 runs, when Mackie was bowled. Williams hit very freely, making 32 before he was bowled. When stumps were drawn the Hospital was 11 runs ahead, having lost 7 wickets.

Scores: 1st innings—St. Bart.'s, 69; St. Annes C.C., 89. Second innings—St. Bart.'s, 83 for 7; St. Annes, 52.

CORRESPONDENCE.

THE CHRISTIAN UNION.

To the Editor, 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—May I draw the attention of your readers to our last meeting this term, which is being held on Thursday, July 7th, at 5 p.m. in the Library? Mr. R. T. Naish has promised to come to speak to us again on the all-important subject of "The Signs of the Near Return of the Lord Jesus Christ."

Yours truly,

St. Bartholomew's Hospital, London, E.C. 1; J. W. C. SYMONDS, *Hon. Sec.*

June 22nd, 1927.

To the Editor, 'St Bartholomew's Hospital Journal.'

DEAR SIR,—I do not grudge you your jests at my expense in your last Editorial, for I, too, have sat in your Chair at a season when jokes were few and columns were long. Since reading your remarks I have read the article to which you apparently refer.

Will you allow me to say (what I hope your readers may have guessed) that the article was a complete misrepresentation, that I did not have an interview with the reporter of any newspaper, and that if I had I should have said something quite different from the absurd remarks attributed to me?

Yours sincerely,

Brook Hospital, Shooters Hill, Woolwich, S.E. 18; EX-EDITOR.

June 23rd, 1927.

PSYCHOLOGICAL TRAINING OF THE PRE-SCHOOL CHILD.

To the Editor, 'St. Bartholomew's Hospital Journal.'

SIR,—May I, a horror-struck parent, enter a mild protest against the whole tenor of the article in the last number of the JOURNAL on the "Psychological Training of the Pre-school Child." It is a maddening article from a parent's point of view.

The subject it deals with is the building of character, and the hypothetical child is pictured as a mite over-charged with emotion, consumed by jealousy and haunted by fear. As it grows older it is forcibly weaned from its mother's breast, and so the first seed is sown which in after-life will grow into a taste for alcohol and pornography. Having developed its interests in bed-wetting, it mistakes circumcision for castration, pinches its younger brother and pulls the wings off flies in the nursery—playful habits with a horrible hidden meaning.

Even if there are some children who develop on these lines it is doubtful if psycho-analysis is good treatment for them. All methods of psychotherapy are dependent on the employment of one or more of three basic principles—suggestion, persuasion and analysis; the first two of these are well-tried methods in the home-training of infants, and it has yet to be shown that analysis is even justifiable.

Fortunately there are some great things, such as life, death, the hereafter or the nothingness hereafter, which defy analysis. Little children belong to this order of things. They need support and encouragement, love and affection; to my mind they need to learn obedience from their earliest days; later they must share their parents' religion and last of all take their place in society. Character is built on such things as these. This scheme is pretty well given

in the well-known words: Honour all men. Love the brotherhood. Fear God. Honour the king.

Yours faithfully,

June 7th, 1927. GEOFFREY EVANS.

To the Editor of 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—Dr. Geoffrey Evans's letter ably illustrates my main point, namely, how extremely difficult it is for a parent—even a distinguished scientific one—to avoid bias and emotional prejudice where his own children are concerned.

I remain, Sir,

Your obedient Servant,

June 24th, 1927. CYRIL WILSON.

To the Editor, 'St. Bartholomew's Hospital Journal.'

SIR,—The following story, as an example of a perverted idea of the Workmen's Compensation Act, I think would be hard to beat. It is an actual fact, this anecdote, and occurred here in Bristol a short while ago. Here it is:

A man was employed by the gas company here, and he was taken ill while at work and had to be attended by his own doctor in his own home. On recovery from his illness he intended to sue the Gas Company (presumably under the Workmen's Compensation Act) as he was treated for, and certified as, suffering from gastritis.

Here is another:

Mr. Brown: I hear your daughter has been ill, Mr. Jones. What's the matter?

Mr. Jones: She's had cataract of the nose.

Yours truly,

11, Victoria Square, CHARLES DIX.
Clifton, Bristol.

REVIEWS.

DISEASES OF THE SKIN. MACKENNA. 2nd Edition. (London: Baillière, Tindall & Cox, 1927.), 25s. net.

The second edition of this text-book ranks it as one of the best on skin diseases to be obtained at the present day.

Four years have passed since the first edition appeared, and the inclusion of 36 coloured illustrations, and of the more recent methods of treatment of various diseases, mark the chief features of the new volume.

It is a pity that the krysolgan treatment of lupus erythematosus is summarily dismissed in four lines, while the thallium treatment of tinea tonsurans, much less valuable, is entered into quite fully.

The ever-increasing vogue for ultra-violet light treatment is reflected generally throughout; probably its sphere of usefulness will sooner or later be considerably curtailed.

For students it is an essentially sound book, and very readable; for practitioners, helpful in diagnosis, and both reliable and clear in lines of treatment. The Appendix is a satisfying skin pharmacopœia.

The publishers are to be congratulated on their handiwork, which is without blemish throughout.

GUY'S HOSPITAL REPORTS. VOL. LXXVII. (Vol. vii, 4th Series.) No. 2, April, 1927.

The present issue of these *Reports* contains a number of unusually interesting articles, including a sequel to a previous communication on "The Pathology of Achalasia of the Cardia." The author (G. W. Rake) has been fortunate, in view of the fact that these patients rarely die, in receiving material from two further cases of this disease. He describes, and publishes photographs of, degenerative changes in Auerbach's plexus as the probable determining factor of the condition.

An extremely thorough investigation, supported by animal experiments, as to the cause of death in acute intestinal obstruction is another important feature of these *Reports*. On the purely clinical side Dr. Maurice Shaw reports a case of recovery from a spontaneous subarachnoid hæmorrhage, thought to be due to a ruptured congenital aneurysm. We have seen several of these cases lately, albeit mostly in the post-mortem room. It is refreshing to read in the words of Dr. Shaw that "progressive recovery (without treatment) is the rule."

INTRACRANIAL TUMOURS. By Sir JAMES PURVES-STEWART. (London: Humphrey Milford, Oxford University Press.) Pp. 206. Illustrated.

There are certain departments of medicine in which some special "modern" method of examination may give the most important clue to the diagnosis. In neurology, however, there is nothing at present which can constantly be of as much value as an accurate clinical examination, and careful studies of clinical cases must ever be of the first importance to neurologists. It is for this reason that Sir James Purves-Stewart's book demands attentive study, for it gives in a concise and critical manner an account of his clinical experience of brain tumour.

In the preface he states that he has notes of 120 cases of verified intracranial tumours, and in the text he gives brief but illuminating accounts of 70 of these, selecting the cases in groups according to their situation and to the particular point he wishes to make. He stresses the faulty diagnoses and attempts to point out how the errors should have been avoided—though it must be admitted that in some of the cases a complete diagnosis must have been an impossibility. In the two final chapters he draws the morals and summarizes the lessons to be learnt from his clinical material.

Made up as it is of case-records the book cannot but be tedious to the "general" reader. But to anyone interested in neurology who has had similar problems to face himself, it is full of information and fascination.

The results of treatment as recorded in the book are most unsatisfactory. Apart from lucky accidents (which are uncommon in medicine), surgery can be of help only when directed by accurate diagnosis. When once this has been made, the poor results obtained in the past must not be regarded as contra-indicating surgery, but should be an incentive to renewed efforts to make surgery effective.

The book is profusely illustrated, the pictures being well selected and clearly reproduced.

THE SCIENCE AND PRACTICE OF SURGERY. Vol. II. By ROMANIS and MITCHENER. (London: J. & A. Churchill.) Pp. 955. Illustrations 666. Price 14s.

This volume maintains the high standard set by the first, and covers the whole of regional surgery. All the facts required for practice or for the Colleges and degree examinations are included, but the details are hardly adequate for the F.R.C.S. or M.S. Many references, however, are made to recent work when space does not permit a full description. The clinical illustrations are particularly good, especially in the chapters on hernia and diseases of the breast. The special department sections are brief but excellent.

It is disappointing that the authors consider the description of the pathology, symptomatology and differential diagnosis of gastric ulcer unsuitable for inclusion, as they are "fully described in medical text-books." The accounts in these books of the pathology are frequently so inadequate, and of the symptomatology so extensive and involved, that a good account would have increased the value of the book. The discussion on treatment is, however, very good.

On the whole the work is very uniform, but in a few instances inspiration or perhaps interest seems lacking. This applies mainly to the section on cranial surgery.

The account of subphrenic abscess is very brief, but a good deal of space is given to the interesting work of Williams on the causation of the toxæmia in acute intestinal obstruction. No mention is made of the metabolic theory of gall-stone formation.

The practice at St. Thomas's in regard to the treatment of acute appendicitis differs from the usual practice in most hospitals, and the authors make a good case for themselves—at least on paper.

The treatment recommended in cases of prostatic enlargement is a little prehistoric; a blind operation followed by the use of the

Hamilton-Irving box is advocated, and if a preliminary cystotomy is advised it is a simple puncture operation.

There are very few mistakes or misprints. On p. 193 the authors presumably mean a preliminary laryngotomy rather than tracheotomy.

The book is well worth an important place among the principal text-books of surgery, and the authors and publishers are to be congratulated on its production.

PYELOGRAPHY: ITS HISTORY, TECHNIQUE, USES AND DANGERS. By ALEX. E. ROCHE, M.D., M.Ch., F.R.C.S. (London: H. K. Lewis & Co., Ltd.) Pp. 118. 16 plates. Price 9s.

Although urological literature is now very extensive and pyelography is constantly referred to in works on urinary surgery, this book fills a gap which has long been present in British medical works. All that the surgeon requires to know about pyelography will be found here. Radiological technique, however, is not fully discussed.

After a very complete review of the different solutions which have been, and are, used for injecting into the pelvis of the kidney for pyelography, the author favours sodium iodide in a strength of 12 per cent. to 15 per cent.

Of the twelve chapters, that on technique is quite the best; for the most minute details with regard to the management of the cystoscope and ureteric catheter, the aspiration of urine from the pelvis, the injection and final aspiration of the pyelographic fluid are carefully and very clearly described.

Full emphasis is laid on the most difficult of all pyelographic problems—that of distinguishing between a normal and a pathological renal pelvis; a full chapter is devoted to the appearance of the normal pelvis.

There are thirteen pyelograms excellently reproduced, mostly performed by the author, which illustrate the points of the text well.

This monograph will prove most useful to all who wish to practise pyelography, but it is only by following a perfect technique, and realizing the difficulties and dangers of this method of renal investigation such as Mr. Roche so ably describes, that useful pyelograms can be obtained without danger to the patient.

SURGICAL INSTRUMENTS AND APPLIANCES. By HAROLD BURROWS. (London: Faber & Gwyer, 1927.) Price 2s. 6d.

This, no doubt, is a very useful book. It gives an adequate supply of helpful information, yet is concisely and briefly written.

Average requirements for every type of operation are carefully listed, in addition to methods of sterilization. The chapter, "Operations in a Private House," is particularly good, as are also the numerous illustrations throughout the book.

It should prove a valuable asset to any student or member of the medical profession.

BRITISH MEDICAL ASSOCIATION.

NINETY-FIFTH ANNUAL MEETING, EDINBURGH.

July 19th to 22nd, 1927.

THE following St. Bartholomew's men, amongst others, are holding office or taking part in the proceedings of the Annual Meeting.

Section of Medicine.—Dr. H. MORLEY FLETCHER is a Vice-President and Dr. GEORGE GRAHAM an Hon. Secretary.

Section of Therapeutics and Pharmacology.—Prof. A. J. CLARK and Prof. FRANCIS R. FRASER are Vice-Presidents; Dr. G. C. LINDER will speak on "Tetany."

Section of Diseases of Children.—Dr. J. HUGH THURSFIELD will speak on "Acute Pneumonia in Early Childhood."

Section of Laryngology and Otology.—Mr. A. R. DINGLEY is an Hon. Secretary.

Section of Preventive Medicine.—Dr. C. W. HUTT is an Hon. Secretary.

Section of Dermatology.—Mr. H. D. HALDIN-DAVIS is a Vice-President.

Section of Tuberculosis.—Dr. R. G. CANTI will speak on "The Pathology of Tuberculosis of Childhood."

Section of Radiology.—Dr. N. S. FINZI will open the discussion on "X-rays and Radium in the Treatment of Carcinoma of the Breast."

Section of the History of Medicine.—Dr. ARNOLD CHAPLIN is a Vice-President; Sir HUMPHRY ROLLESTON will open the discussion on "The Historic Evolution of Disease." Prof. A. J. CLARK will read a paper on "The Historical Aspect of Quackery."

RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEW'S MEN.

CHANDLER, F. G., M.A., M.D., F.R.C.P. "The Diagnosis of Early Pulmonary Tuberculosis." *Practitioner*, June, 1927.

DAVIES, IVOR J., M.D., F.R.C.P. "Anæmia (including Pernicious Anæmia)." "Arthritis Deformans." "Blood Transfusion." "Chloroma." "Endocrinology." "Erythræmia (Polycythæmia Vera, Vaquez-Osler Disease." "Fireman's Cramp." "Focal Sepsis." "Exophthalmic Goitre." "Leukæmia." "Obesity." "Pharmacology and General Therapeutics." "Physical Examination." "Ectoscopy." "Poisoning." "Congenital Porphyrinuria." "Purpura Hæmorrhagica." "Raynaud's Disease." "Acute Rheumatism." "Seasickness." "Tularæmia." *Medical Annual*, 1927.

GAUVAIN, Sir HENRY J., M.A., M.D., M.C. "Phototherapy." *Medical Annual*, 1927.

GROVES, ERNEST W. HEY, M.D., F.R.C.S. "Painful Back." "General Bone Disease." "Foot-drop and Flail Foot." "Fractures." "Genu Valgum." "Surgery of Hip-joint." "Surgery of Paralysis." "Surgery of Sacro-iliac Joint." "Surgery of Spine." "Ingrowing Toe-nail." *Medical Annual*, 1927.

HANNAN, JOHN H., M.A., M.D., B.Ch.(Cantab.). *The Flushings of the Menopause.* London: Baillière, Tindall & Cox, 1927.

HODGE, B. LLEWELYN, M.R.C.S., L.R.C.P. "Spontaneous Rupture of the Right Ventricle of the Heart." *British Medical Journal*, June 18th, 1927.

HURRY, JAMIESON B., M.A., M.D. (and FENWICK, E. DOROTHY, M.R.C.S.). "Visceroptosis and Its Vicious Circles." *Clinical Journal*, May 25th and June 1st, 1927.

LISTER, A. E. J., M.B., B.S., F.R.C.S. "Cataract." "Diseases of Conjunctiva." "Diseases of Cornea." "Eye Affections Associated with Disease of other Organs." "General Eye Affections." "Glaucoma." "Optic Nerve Disease." "Errors of Refraction." "Diseases of Retina." *Medical Annual*, 1927.

NIXON, J. A., C.M.G., M.D., F.R.C.P. "The Use of Insulin in Surgery." *Clinical Journal*, June 1st, 1927.

ROBINSON, WILLIAM VALENTINE, D.M., M.A., B.Ch. "Light Literature." *Clinical Journal*, June 15th, 1927.

ROCHE, ALEX. E., M.A., M.D., M.Ch.(Cantab.), F.R.C.S. *Pyelography: Its History, Technique, Uses and Dangers.* London: H. K. Lewis & Co., 1927.

ROXBURGH, A. C., M.D. "The Treatment of Insect Bites and Stings." *Lancet*, May 28th, 1927.

WALKER, KENNETH M., F.R.C.S., M.A., M.B., B.C. "Some Points in the Treatment of Prostatic Obstruction." *Clinical Journal*, June 15th, 1927.

WARING, Sir HOLBURT, M.S., B.Sc., F.R.C.S. *Manual of Operative Surgery.* 6th Edition. London: Humphrey Milford, Oxford University Press, 1927.

WHARRY, H. MORTIMER, F.R.C.S. "The Epiglottis in Respiratory Obstruction under Anæsthesia." *British Medical Journal*, May 21st, 1927.

WOODWARK, A. S., C.M.G., C.B.E., M.D., F.R.C.P. *Manual of Medicine.* 3rd Edition. London: Humphrey Milford, Oxford University Press, 1927.

EXAMINATIONS, ETC.

UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred:
M.D.—Dalton, C. H. C., Hannan, J. H., Roche, A. E.
M.B.—Dicks, H. V., Spence, A. W.
M.B., B.Chir.—Ware, H. A.

UNIVERSITY OF LONDON.

Third (M.B., B.S.) Examination for Medical Degrees, May, 1927.
Honours.—Freeman, E. A. (*d*).
(*d*) Distinction in Surgery.

Pass.—Blount, D. A., Brigg, D. A., Cochrane, T. S., Curtiss, E. S., Dean, J., Eyton-Jones, F. M. M., Fraser-Smith, A. E., Gilsenan, B. M. C., Greenwood, W. Pickup, Hiscocks, H. F., Roberts, J. H. O., Whitton, J. S.

Supplementary Pass List. Group I.—Dewhirst, D. A., Huss, C. B., Lewys-Lloyd, R. A. V.

Group II.—Cholmeley, J. A., Fells, R. R., Flockton, P. H., Forrest, J. R., Hobbes, T. H., Maley, M. L., Nicol, W. D.

ROYAL COLLEGE OF SURGEONS.

The Diploma of *Fellow* has been conferred upon the following: Armstrong, H. G., Bullen, H. B., Gwillim, C. M., Roberts, E. L.

APPOINTMENTS.

ADDISON, V. H., M.R.C.S., L.R.C.P., appointed House Surgeon to Queen Mary's Hospital for the East End.

MILLER, T. MACKINLAY, M.C., M.R.C.S., L.R.C.P., appointed Hon. Anæsthetist to Tonbridge Wells and Counties General Hospital.

MORGAN, E. W., M.R.C.S., L.R.C.P., appointed Junior House Physician to the Prince of Wales Hospital, Tottenham, N. 1.

BIRTHDAY HONOURS.

In the Birthday Honours the K.B.E. has been conferred on Dr. C. P. B. Clubbe in recognition of services to the Commonwealth of Australia.

CHANGES OF ADDRESS.

LAWRENCE, S. M., The Limes, Buckingham; (Surgery) 7, Castle Street, Buckingham.

MOORE, Sir ALAN, Bart., Southover Old Rectory, Lewes.

POOLE, J. W., "Buckingham," High Road, Whetstone, N. 20.

SHAH, B. Z., Maj. I.M.S., c/o Lloyds Bank, Bombay, India.

BIRTHS.

CRIPPS.—On June 15th, 1927, at Cradock, South Africa, the wife of W. Laurence Cripps, F.R.C.S., of a daughter.

CROOK.—On June 5th, 1927, at 15, South Eaton Place, London, S.W. 1, to Elizabeth (*née* Garratt), the wife of Eric A. Crook, F.R.C.S.—a daughter.

NIXON.—On May 27th, 1927, at 7, Lansdown Place, Clifton, Bristol, Doreen, the wife of Dr. J. A. Nixon—of a daughter.

THOMSON.—On June 7th, 1927, to Doris (*née* Pering), wife of Dr. N. Gray Thomson, of Lavington, Barnet, Herts—the gift of a son.

WALKER.—On June 5th, 1927, at 3, Boundary Road, N.W. 8, to Mr. and Mrs. Kenneth Walker—a daughter.

MARRIAGE.

DAY—MILLER.—On June 1st, 1927, at Eaton Parish Church, by Rev. Canon Bell, M.A., assisted by Rev. H. Webster, M.A., George, son of Mr. and Mrs. Donald Day, of Norwich, to Amélie Joan, only daughter of the late Arnold Miller and of Mrs. Miller, of Eaton, Norwich.

SILVER WEDDING.

KELF—DAVIES.—On June 9th, 1902, at St. John's Church, Westminster, by the Ven. Archdeacon Wilberforce, D.D., Henry D. Kelf to Clara Davies, late of Christchurch, N.Z. Address, "Harclere," Basingstoke.

DEATHS.

FRANEY.—On June 13th, 1927, at Banbury, Oxon, Edward Franey, M.R.C.S., L.S.A., aged 92.

GORDON.—On June 19th, 1927, James Edward Gordon, O.B.E., M.R.C.S., L.R.C.P., of 52, Endless Street, Salisbury, aged 55.

ACKNOWLEDGMENTS.

British Journal of Nursing.—Broadway.—Giornale della Reale Società Italiana d'Igiene.—Guy's Hospital Gazette.—The Hospital Gazette.—The Kenya Medical Journal.—London Hospital Gazette.—Long Island Medical Journal.—The Medical Review.—The Nursing Times.—The Post-Graduate Medical Journal.—Queen's Medical Magazine.—Revue de Medicin.—St. Thomas's Hospital Gazette.—The Student.—Sydney University Medical Journal.—U.C.H. Magazine.—University of Toronto Medical Journal.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, E.C. 1.*

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLANS, M.B.E., B.A., *at the Hospital.*

All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, *The Journal Office, St. Bartholomew's Hospital, E.C. 1. Telephone: City 0510.*